



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 02-012	2. STATE GEORGIA
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE October 1, 2002	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440.230 and 441.56(C)(2)		7. FEDERAL BUDGET IMPACT: a. FFY 2003 \$ No Budget b. FFY 2004 \$ Impact	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, page 4c		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable). Attachment 3.1-A, page 4c	
10. Subject of Amendment MODIFICATION OF EPSDT DENTAL SERVICES			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input checked="" type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. Return to: Department of Community Health Division of Medical Assistance 2 Peachtree Street, NW Atlanta, Georgia 30303-3159	
13. TYPED NAME: MARK TRAIL			
14. TITLE: Director, Division of Medical Assistance			
15. DATE SUBMITTED: December 2, 2002			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: December 5, 2002		18. DATE APPROVED: January 28, 2003	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2002		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Rhonda R. Cottrell		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS:			

10b. EPSDT DENTAL

All medically necessary dental services will be provided to all recipients under age 21 when these services are provided at intervals that meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved with child health care, and at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition.

Prior Approval is required for the following dental services:

Emergency services are exempt from prior approval but must be submitted for post-treatment review.

Hospital admissions, inpatient and outpatient.

Root canal therapy.

Anesthesia including nitrous oxide, intravenous sedation and general anesthesia.

Chemotherapy, therapeutic.

Other drugs and medicants.

More than two denture adjustments, one laboratory relining, or two tissue conditionings per recipient, per calendar year.

Catastrophic procedures, except emergency treatment.

Orthodontic treatment.

Dentures.

Management of difficult children.

Hospital time/consultation.

Periodontal Services.

Alveoloplasty with extractions.

Alveoloplasty without extractions.

Ambulatory Surgical Center Outpatient Admissions.

TN No. 02-012

Supersedes Approved January 28, 2003 Effective Date October 1, 2002

TN No. 01-018

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